

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by the Cape Fear Eye Associates, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Cape Fear Eye Associates, P.A. I understand that diagnosis or treatment of me by the healthcare providers of the Cape Fear Eye Associates, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Cape Fear Eye Associates, P.A. is not required to agree to the restrictions that I may request. However, if Cape Fear Eye Associates agrees to a restriction that I request, the restriction is binding on the Cape Fear Eye Associates, P.A. and its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent the Cape Fear Eye Associates has take action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "protected health information" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand I have the right to review the Cape Fear Eye Associate's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of health care operations of Cape Fear Eye Associates.

The Notice of Privacy Practices for the Cape Fear Eye Associates is located at the reception desk. This Notice of Privacy also describes my rights and Cape Fear Eye Associates' duties with respect to my protected health information.

The Cape Fear Eye Associates, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

*The final HIPAA privacy rules prohibit the notice and consent
from being combined into a single document.*

*Cape Fear Eye Associates, P.A.
Patient Consent Form*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Cape Fear Eye Associates at (910) 484-2284 or at 1726 Metro Medical Drive, Fayetteville, North Carolina 28304.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature

Date